STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/10/24 Facility Number: 000450 Provider Number: 155801 AIM Number: 100273890 At this Emergency Preparedness survey, Transitional Healthcare of Boonville-North was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 56 certified beds. At the time of the survey, the census was 53. Quality Review completed on 12/12/24	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 1/6/2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on December 10, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/10/24 Facility Number: 000450 Provider Number: 155801 AIM Number: 100273890 At this Life Safety Code survey, Transcendent	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 1/6/2025 to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Van Hoy	Administrator	12/26/2024

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	Healthcare of Boonville-North was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 56 and had a census of 53 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/12/24		the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on December 10, 2024.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review and interview, the facility failed to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the	K 0300	K - 300 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now updated the policy on battery operated smoke alarms, which includes the instructions to test the alarms at least monthly or	01/06/2025

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	equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on record review on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and the Maintenance Supervisor present, the "Room Smoke Detector Battery Operated Monthly Inspection Log" showed monthly testing of the battery operated smoke alarms. The manufacturer's published instructions on the back side of each smoke alarm stated the alarms require weekly testing. Based on interview at the time of records review, the Maintenance Supervisor stated the alarms are tested monthly, and agreed the alarms should be tested weekly according to manufacturer's published instructions. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)		more frequently as outlined by the smoke alarms specific manufacturer guidelines. The smoke alarms are now being tested weekly in accordance with their specific manufacturer guidelines. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now updated the policy on battery operated smoke alarms, which includes the instructions to test the alarms at least monthly or more frequently as outlined by the smoke alarms specific manufacturer guidelines. The smoke alarms are now being tested weekly in accordance with their specific manufacturer guidelines. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the revised smoke alarm policy to ensure their understanding of the requirement to test the smoke alarms in accordance with the manufacturer guidelines and per the regulatory requirements. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a	

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			Quality Assurance tool has been developed and implemented to monitor the testing of the smoke alarms to ensure they are being tested in accordance with the new revised smoke alarm policy. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on record review and interview, the facility failed to ensure there was documentation available to show 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the	K 0324	K - 324 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors in the main dining area have the potential to be affected by this deficient practice. The facility has now had the range hood exhaust system inspection completed and the documentation of this inspection is on file in the facility records. The maintenance supervisor will ensure that these inspections will be completed semi annually in compliance with the regulations. *The corrective action taken for the*	01/06/2025

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	authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff and residents, staff, and visitors while in the main dining room. Findings include: Based on record review on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, there was no current semiannual inspection report available to review for the range hood exhaust system. The most recent range hood exhaust system inspection report available to review was dated 04/18/24. Based on interview at the time of record review, the Maintenance Supervisor said he was aware that the inspection for the kitchen range hood was almost two months past due and has already been in contact with the vendor and they are scheduled to perform the inspection on 12/18/24. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)		*other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors in the main dining room have the potential to be affected by this deficient practice. The facility has now had the range hood exhaust system inspection completed and the documentation of this inspection is on file in the facility records. The maintenance supervisor will ensure that these inspections will be completed semi-annually in compliance with the regulations. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all maintenance staff on the regulation related to the semi-annual range hood exhaust system inspection requirements. The staff has been re-educated on their responsibility of ensuring that these inspections are scheduled and completed in a timely manner and that a copy of each inspection is maintained on file in the facility. Upon completion of each inspection, the maintenance supervisor will then schedule the next inspection for six months following the most recent inspection. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the	

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			maintenance supervisor is now required to submit each semi-annual range hood exhaust system inspection report to the Executive Director for review to ensure timely completion of this task. This will be an on-going process.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection dated 11/22/24 by the facility's fire alarm inspection vendor, furthermore,	K 0345	K 345 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had a visual inspection of the facility's fire alarm system including the smoke detectors and heat detectors. There is documentation of this visual inspection on file at the facility. The facility will continue to ensure that semi-annual visual inspections are conducted of the facility's fire alarm system including the smoke detectors and heat detectors. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient	01/06/2025

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	there were quarterly inspections available dated 02/20/24, 05/29/24, and 08/23/24 by the facility's fire alarm inspection vendor, however, the quarterly inspection documents did not provide information about a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors and heat detectors. For each device listed on each of the quarterly reports it said, "Not Tested". The facility's pull stations were tested during each quarterly inspection. Based on interview at the time of record review, the Administrator agreed the quarterly inspections did not provide information of a semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors and heat detectors. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure complete documentation was available for the sensitivity testing of all hard wired smoke detectors, and to show what testing instrument was used to test all smoke detectors for sensitivity. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent		practice. The fire alarm system inspection vendor was contacted by the facility. The fire alarm system inspection vendor's report now contains the information on what testing instrument was used to test all smoke detectors for sensitivity. A copy of this report is now on file at the facility. All future fire alarm system inspection reports will contain all the required information as outlined by the regulation. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had a visual inspection of the facility's fire alarm system including the smoke detectors and heat detectors. There is documentation of this visual inspection on file at the facility. The facility will continue to ensure that semi-annual visual inspections are conducted of the facility's fire alarm system including the smoke detectors and heat detectors. The fire alarm system inspection vendor was contacted by the facility. The fire alarm system inspection vendor's report now contains the information on what testing instrument was used to test all smoke detectors for sensitivity. A copy of this report is now on file at	

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	trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, there was documentation available to show a smoke detector sensitivity test of all hard wired smoke detectors was performed on 11/22/24 by the facility's fire alarm system inspection vendor, however, the report did not include the name of the manufacturer's calibrated sensitivity test instrument. This was confirmed by the Administrator at the time of record review.		the facility. All future fire alarm system inspection reports will contain all the required information as outlined by the regulation. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on what information must be included in each fire alarm system inspection report. The maintenance supervisor has been advised of their responsibility to ensure that each fire alarm system inspection report is complete in its entirety to include all items as outlined by the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a copy of each fire alarm system inspection report will now be submitted to the Executive Director for review to ensure that all components of the report are complete and that all required documentation has been completed on each report. This will be an on-going process.	

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	This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include the following: a. A time frame for starting the fire watch if the fire alarm system is out of service. b. Contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, this was confirmed by the Administrator. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference.	K 0346	K - 346 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire watch policy to include the time frame for starting the fire watch if the fire alarm system is out of service, as well as the contact information for IDOH web link for contacting the incident reporting system location on the IDH gateway. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire watch policy to include the time frame for starting the fire watch if the fire alarm system is out of service, as well as the contact information for	01/06/2025

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	3.1-19(b)		IDOH web link for contacting the incident reporting system location on the IDH gateway. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff members on the revised fire watch policy with special instructions in the area of when to start the fire watch and how to report the fire system outage to IDOH. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the changes to the facility's fire watch policy will be reviewed at the facility's Quality Assurance meeting to determine if any additional changes are warranted and to ensure that the policy meets all the requirements of the regulation.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler heads under 1 of 1 front porch entrance/exit overhang covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in	K 0353	K - 353 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The four corroded sprinkler heads identified on the front porch overhang have now	01/06/2025

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	the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 5 or more resident, as well as staff and visitors while using the front porch area. Findings include: Based on observations on 12/10/24 between 3:00 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there were four sprinkler heads under the front porch entrance/exit overhang covered with corrosion. Based on interview at the time of observation, the Administrator and Maintenance Supervisor agreed the four sprinkler heads under the front porch overhang were covered with corrosion. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)		been replaced and are free of any corrosion. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents staff and visitors have the potential to be affected by this deficient practice. A house wide inspection of all sprinkler heads has now been completed and all are free of any dirt, debris or corrosion. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance and housekeeping department related to their responsibility to ensure that all sprinkler heads are kept clean and free of debris or corrosion. The staff was reminded to immediately report any signs of corrosion of a sprinkler head to the maintenance department so that arrangements can be made promptly for the replacement of the identified sprinkler head. In addition, the facility's fire system vendor is schedule to conduct quarterly inspections of all sprinkler heads and replace any sprinkler heads that are corroded to ensure their proper functioning. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will keep facility records on all quarterly	

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			inspections of the sprinkler heads conducted by the fire system vendor as well as records of all sprinkler head replacements on file at the facility for inspection.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, the facility did provide fire watch documentation, however, it was	K 0354	K - 354 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire watch policy to include the time frame for starting the fire watch if the fire alarm system is out of service, as well as the contact information for IDOH web link for contacting the incident reporting system location on the IDH gateway. The policy was also amended to include the name and contact information of the facility's insurance company. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire watch policy to include the time frame for starting the fire watch if the fire	01/06/2025

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	155801	A. BUILDING 01 B. WING	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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	incomplete. The plan failed to include the following: a. A time frame for starting the fire watch if the sprinkler system is out of service. b. Contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway, as well as contact information for the facility's Insurance Company. Based on an interview at the time of record review, this was confirmed by the Administrator. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)		alarm system is out of service, as well as the contact information for IDOH web link for contacting the incident reporting system location on the IDH gateway. The policy was also amended to include the name and contact information of the facility's insurance company. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff members on the revised fire watch policy with special instructions in the area of when to start the fire watch, how to report the fire system outage to IDOH as well as the contact information of the facility's insurance company. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the changes to the facility's fire watch policy will be reviewed at the facility's Quality Assurance meeting to determine if any additional changes are warranted and to ensure that the policy meets all the requirements of the regulation.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Based on observation and interview, the facility failed to ensure 4 of 4 fuel-fired tankless water heaters had inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health	K 0500	K - 500 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no	01/06/2025

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TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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	facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations on 12/10/24 between 3:00 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there were four tankless fuel-fired water heaters in the Mechanical Room that were provided with blue State/Homeland Security identification tags, however, there were no inspection stickers or certificates available to review. Based on interview at the time of observation, the Administrator confirmed all four fuel-fired tankless water heaters were not provided with inspection stickers or certificates to review. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)		specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had the four fuel-fired tankless water heaters identified during the survey inspected and the inspection certificates are in place in accordance with the regulation. Annual inspections will continue to be conducted per the regulation. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had the four fuel-fired tankless water heaters identified during the survey inspected and the inspection certificates are in place in accordance with the regulation. Annual inspections will continue to be conducted per the regulation. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for the maintenance supervisor on their responsibility to ensure that annual inspections are conducted per regulation on all fuel-fired tankless water heaters and that the required certifications are posted as required. *The corrective action taken to monitor to ensure the deficient*	

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TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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			practice will not recur is that the maintenance supervisor will now provide the Executive Director annually with the supportive documentation of the required inspections of all fuel-fired tankless water heaters for their review to ensure compliance.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states that any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled	K 0711	K - 711 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now revised their fire safety plan to include the following; identifying the staff member who is responsible for calling 911 in the event of a fire emergency, identifying where the smoke barriers were located in the facility and evacuation in detail, the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead exhausting system, and the staff response to the activation of the battery powered smoke alarms. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all	01/06/2025

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	equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Emergency Procedure-Fire plan on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, the plan did not address the following: a. Identifying the staff member who is responsible for calling 911 in the event of a fire emergency. b. The plan did address evacuation of the smoke compartment; however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. c. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. d. Staff response to the activation of battery powered smoke alarms. Based on interview at the time of record review, the Administrator and Maintenance Supervisor acknowledged the Emergency Procedure-Fire plan did not include the previously mentioned items. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b)		residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now revised their fire safety plan to include the following; identifying the staff member who is responsible for calling 911 in the event of a fire emergency, identifying where the smoke barriers were located in the facility and evacuation in detail, the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead exhausting system, and the staff response to the activation of the battery powered smoke alarms. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the revisions of the facility's fire safety plan with a focus on the additions to the plan. Each staff member was instructed on their responsibilities in following the fire safety plan. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the fire safety plan will be reviewed at least annually at the facility's Quality Assurance meeting to ensure that the fire safety plan is complete and accurately meeting all regulatory requirements.	
K 0712 SS=C	NFPA 101 Fire Drills			

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Bldg. 01	Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, 4 of 4 third shift (night) fire drills were 10:15 p.m. and 11:31 p.m. Based on interview at the time of record review, the Administrator and Maintenance Supervisor acknowledged the times of the third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	K - 712 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted a fire drill on third shift at a staggered time which was at least two hours different from the past two fire drills. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted a fire drill on third shift at a staggered time which was at least two hours different from the past two fire drills. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for the maintenance supervisor on their responsibility to ensure that fire drill times are staggered to ensure that they do not occur around the same time frame on the same shift. The fire drills will be staggered so that they do not consistently occur around the same time as the previous time on	01/06/2025

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			each shift. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* all fire drill reports will now be submitted to the Executive Director for review to ensure that the time frames of the fire drill times are staggered. This review will be on on-going process.	